INFUSION CENTER OF NEW ENGLAND

Checklist for Ocrevus (ocrelizumab) Referral

Patient Name: _____ **DOB:** _____ **Date:** _____

Referring Physician: _____ **NPI:** _____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ **Office Fax:** _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ❑ Patient demographic information
- ❑ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ❑ Supporting clinical notes and office visits. Two notes preferred.
  - Note should include any therapies tried/failed, and must include discussion about Ocrevus
  - Medication list and allergies
  - Last Ocrevus infusion note, if available
- ❑ Supporting lab reports/orders for Ocrevus treatment
  - Baseline: CBC w diff, CMP, serum immunoglobulins, Hepatitis B screening, tuberculosis screening, and brain MRI within 1 year
  - *For continued therapy:* CBC w diff and CMP prior to each infusion
  - Ensure all vaccinations are up to date prior to treatment. Live vaccines should be given at least 4 weeks prior to treatment, and non-live vaccines should be given at least 2 weeks prior to treatment.
- ❑ Ocrevus Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible –

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 ext. 112

Visit our website: www.InfusionCenterNE.com
Email: InfusionCenter@myneurodr.com

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Prescribing Order: Ocrevus (ocrelizumab)

Date of Order: _____ ❑ New Start ❑ Maintenance
Date of last infusion: _____

Patient Name: _____ **DOB:** _____ **M/F:** ____

Diagnosis (include ICD-10 code/s):_____

❑ **NKDA** **Allergies:** _____

Patient Weight: _____

Premedication:

❑ Acetaminophen 1000mg PO
❑ Loratadine 10mg or Cetirizine 10mg PO
❑ Diphenhydramine 25mg PO
❑ Diphenhydramine 25mg IV
❑ Solu-medrol 125mg IV in 50ml over 15min
❑ Other: _____

Lab Orders:

❑ CBC w/diff, CMP every _____ weeks
❑ Other**:** _____
_____

Ocrevus Medication Order: ****Use 0.2 micron filter for administration****

- ❑ **Ocrevus 300mg/250ml NS IV on Day 1 and Day 15. Begin infusion at 30ml/hr and increase by 30ml/hr every 30min to a maximum rate of 180ml/hr.**
- ❑ **Ocrevus 600mg/500ml NS IV once every 6 months. Begin infusion at 40ml/hr then increase rate by 40ml/hr every 30 minutes to a maximum rate of 200ml/hr until completion.**
- ❑ **Shorter Infusion Time: Ocrevus 600mg/500ml NS IV once every 6 months. Begin infusion at 100ml/hr for the first 15 min, increase to 200ml/hr for the next 15 min, increase to 250ml/hr for the next 30 min, then increase to 300ml/hr for the remaining 60 min.**

✓ Post infusion observation: Required for 1 hour after Ocrevus completion
- ❑ NS 100ml/hr x 1 hour

Administration:

- ✓ Vital Signs: Pre-treatment then every 30 minutes during infusion
- ✓ Do not administer if patient has signs or symptoms of active infection
- ✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

Ordering Provider Name **NPI**

Signature **Date**

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671